State of California—Health and Human Services Agency

California Department of Public Health



California Medical Waste Management Program TRAUMA SCENE AND MEDICAL WASTE TRANSPORTER IDENTIFICATION/FACILITY UTILIZATION

Mail to:

California Department of Public Health Medical Waste Management Program MS 7405

P.O. Box 997377 Sacramento, CA 95899-7377

Owner's name Company name Mailing address City State ZIP code Telephone number () EMAIL OR WEB Address: Contact person		Publichealth											
Company name Mailing address City State ZIP code	Owner's name						Hazardous waste hauler registration number DTSC Reg			gistration Expiration Date:			
Telephone number							Operator's name						
Mimportant: A copy of the service agreement with the off-site treatment facility is REQUIRED. For trauma scene waste practitioner renewals, also include recent proof of disposal or pickup contract. Year							Mailing address			State	ZIP code	ZIP code	
Year Make Model Cargo Body Capacity (in Cubic Feet) Cargo Body Capacity (in lb.) Vehicle ID Number License Number (truck, van, tractor only, trailer only, roll-off container) Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the medical waste transfer station and/or treatment facility used. Provide information on the m	Telephone number FAX number EMAI					IL OR WEB Ad	ddress:	Contact person	Contact person				
Year Make Model (in Cubic Feet) (in Ib.) Vehicle ID Number License Number (truck, van, tractor only, trailer only, roll-off container)	lmpor				treatment fac	ility is REQ	UIRED. For trauma so	cene waste pr	actitioner r	enewals	, also includ	de recent	
Facility Utilized Facility Address (City/State/ZIP code) Off-Site Transfer Station Yes \(\sum_{No} \)	Year	Make					Vehicle ID Number	License	License Number		(truck, van, tractor only,		
Facility Utilized Facility Address (City/State/ZIP code) Off-Site Transfer Station Yes \(\sum_{No} \)													
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Facility Utilized (City/State/ZIP code) Treatment Station Yes No Yes No	Provid	de information or	n the medical	waste transfer station and/or				•		•			
		Facility Utili	zed	Facility Address (City/State/ZIP code)									
□ _{Yes} □ _{No} □ Yes □ _{No}									□Y	′es 🗆	No ☐ Yes	\square_{No}	
									□Y	′es 🗆	No ☐ Yes	□ _{No}	

For medical waste transporters: Annually provide the Department with a list of all medical waste generators serviced during the previous 12 months and updated vehicle information (HSC, Section 118029). Also, pursuant to HSC, Section 118040, provide a copy of the medical waste tracking document utilized. Attach additional sheets when necessary to complete your response.